reviews

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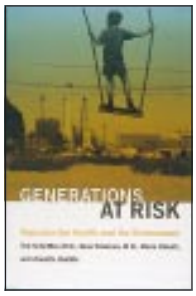
Generations at Risk: Reproductive Health and the Environment

Ted Schettler, Gina Solomon, Maria Valenti, Annette Huddle



MIT Press, £20.95, pp 430
ISBN 0 262 19413 9

Rating: ★★

Children are among the most sensitive populations to environmental health hazards. Their routine exposure to toxic chemicals in homes and communities can put them at risk of health problems. Central to the ability to protect our communities and families is exercising our right to know about toxic hazards. For many, the only source of environmental information is media reports, which often leave the public feeling confused and powerless. Making sense of pages of information and data presented in different formats and measurement units is a challenge to *BMJ* reviewers let alone people with non-technical backgrounds. To benefit from public access to information, the community needs details of how to obtain useful environmental and health information, resources for interpreting these sources, an understanding of basic principles for evaluating health risks, knowledge of how to obtain help in understanding technical or specialised information, and familiarity with strategies for pollution prevention or risk reduction.

Between 1969 and 1979, 12 children were diagnosed with leukaemia in Woburn, Massachusetts. The first to notice that too many childhood leukaemias were being identified in her neighbourhood was one of the children's mothers. Shortly after the cluster was identified, environmental agencies found that chemicals from a nearby industrial property had contaminated drinking water in the area. These citizens' efforts to prompt research and to address this tragic health problem have provided important lessons on community environmental health advocacy, as well as inspiring the film *Civil Action*. Would accessible information have helped their search?

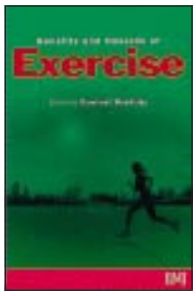
Generations at Risk describes itself as a source book on human exposure to toxic chemicals that can have reproduction and development effects. Its suggested readership is those concerned about their family's health and medical and public health workers. It attempts to provide scientific information with which to assess the health risk of many chemicals, as well as a guide to regulatory systems and resources for action. It presents summaries on reproductive and developmental physiology and the role of science in public health decisions, and is a useful primer for clinicians. Treatises on substances and exposures are less accessible, however, especially to the non-technical citizen, and the emphasis on US regulations and sources diminishes its broader appeal.

Would it have helped the citizens of Woburn by giving them scientific information in a readable form? Unfortunately, it only rises partially to the challenge. It's well worth a dip for the specialist, but not for its declared broader audience.

Donald Campbell *public health medicine specialist, Public Health Protection, Auckland Healthcare, New Zealand*

The Benefits and Hazards of Exercise

Ed Domhnall MacAuley



BMJ Books, £35, pp 394
ISBN 0 7279 1412 X

Rating: ★★★★

Many patients approach their general practitioner confused about exercise. Some of those who exercise get training tips from hearsay and don't base their training on scientific principles. Worse, many patients don't exercise at all and attribute their inactivity to their medical problems; these are often the patients who need exercise the most. *The Benefits and Hazards of Exercise* clarifies some of the confusion by giving an up to date, critical review of exercise recommendations and exercise topics.

The first chapters approach exercise from a public health perspective, including how much exercise is enough to improve health. The book then ventures into exercise as a form of disease management for hypertension, diabetes, and other chronic conditions. The chapter on the effect of exercise on mental wellbeing is particularly intriguing. The last chapters focus on physiological responses to exercise and how external factors such as altitude affect performance.

As a multiauthored text, the chapter format differs throughout. Some authors approach their topic as a traditional review of the literature. Many, however, use a meta-analysis approach, describing how they analysed the literature to make their recommendations. The chapter on viral illness and sport is disappointing. Because of the paucity of literature on this topic, the chapter reads more like a research grant application than a review. Review questions accompany each chapter. In most chapters, the questions highlight the main educational points, although the changes in format from chapter to chapter were somewhat disruptive.

For general practitioners, the book is extremely helpful for ideas to motivate patients on both an individual and community basis. This book doesn't seem to be intended for elite athletes interested in training tips (such as adding plyometric training to increase vertical leap). It does, however, address areas such as jet lag, rehydration strategies, and altitude training that can give elite athletes a competitive advantage. Often, this most extreme segment of the exercising population can have the most bizarre training concepts, and the relevant chapters of this book give the physician valuable information when counselling such athletes.

As most of the book was educational and well written, I wish it could have included a few more subjects. One missing topic was using exercise as a method for treating obesity. A specific section would have been useful as obesity is a prevalent disease associated with inactivity. The risks and benefits of a stretching programme as part of an exercise routine would also have been interesting. Otherwise, the book is an excellent guide to the major issues of exercise that are pertinent to physicians.

A Pasternak *family physician, Reno, Nevada, USA*

Reviews are rated on a 4 star scale (4=excellent)

PERSONAL VIEW

Doctors have become more caring than nurses

How life changes. As a clinical nurse, manager, and educationalist who is about to celebrate 25 years in nursing in some guise or another, never would I have imagined that I would admit that the medical profession has become more caring than my own. Yes, those very same nurses, who I believed prided themselves in providing high quality personal care, the real essence of nursing, have changed. What I see now bears little resemblance to the service I entered. An unfeeling leviathan seems to have been created.

Sadly, I reach this conclusion after a short spell in a large teaching hospital. I had what ministers would describe as a patient experience. Many members of my profession will undoubtedly view me as a heretic, and I can understand them. But nurses must take stock of where nursing is going before it is too late.

Nurses have been indoctrinated with the belief that doctors are capable of exercising only a cold, scientific medical model. They treat the disease, not the patient. Nursing literature is full of anecdotal accounts of the distant approach that doctors have towards patients and their carers. Nurses, on the other hand, claim to practise in a holistic manner, caring, not purely about individuals' physical wellbeing, but also their emotional and spiritual needs.

Rapid changes in technology and new treatments have necessitated changes in nursing practice. Many of these have been welcomed. Nurses have extended their clinical competencies, and as a result have challenged traditional roles of other healthcare professionals, particularly doctors. This would seem to be in line with the government's modernisation agenda for the NHS to improve access, shorten the wait in the system, and decrease lengths of stay.

> Nurses must take stock of where nursing is going before it is too late

Indeed nurses may congratulate themselves in that the profession has spent the past two decades building up its unique body of knowledge, complex theories based on sociology and psychology, creating a pseudo science out of assessing patients, and writing care plans as part of the nursing process. But in this somewhat evangelical search for professional status nursing has slipped into the same trap as befell other professions and has created a professional mystique all of its own, with its own complex language and behaviours.

Nurses claim to practise patient centred care, based on problem solving and the search for resolving individual health needs. I must challenge this. What good are sophisticated and lengthy care plans that bear little or no relevance to the actual care that patients receive? It is purely an academic exercise.

As a patient, I looked to nurses to make me comfortable and to restore my independence. I believed that they would help maintain my hygiene, tend to my nutritional needs, and keep me free from pain. Sadly, all this was lacking. On the other hand, my cannula was well positioned and my antibiotics were given intraveneously with great regularity, and my cardiac monitor was interrogated and monitored regularly. But caring seemed to be viewed as subordinate or perhaps it was not seen as important at all.

As the vocation of nursing has evolved into the profession, we seem to have lost fundamental values, in particular a concern for patients. Nursing now focuses less on patients and more on the acquisition of knowledge and skills purely to further its status. I am terrified that we have on the horizon a new breed of nurses, nurse consultants, who may well have modelled themselves on the Sir Lancelot Spratt school of medicine. Perhaps they are motivated by a belief that it is time to seek retribution for the years of oppression by the medical profession.

A caring ethic and professionalism need not be mutually exclusive. It was interesting to witness how medical staff now seem to be able to combine both traits. Who was it who made me comfortable and cared about my wellbeing as I lay helpless in my bed? It was the medical team. The nurses were no doubt busy, but busy doing what? It was not caring.

Nursing is not yet a mature profession. Like an adolescent it manifests behaviours that challenge those around. This is not necessarily all bad but nurses must not lose the confidence of patients and colleagues at the same time.

Let there be a warning to nurses, managers, and educationalists. Professionalisation in itself will not guarantee improved patient care. Our only hope is to re-educate nurses to care again. Or is it too late?

M Fletcher *nurse and health service manager, Birmingham*

WEBSITE OF THE WEEK

Making websites This week's nursing theme in the *BMJ* prompted me to seek out the nursing locales on the internet—and reflect on the role of the lone producer of an internet resource. One such person is Melanie X, founder of Nursing.Point (www.nursing.point.btinternet.co.uk/), who serves a frames based site of links of interest to nurses. She's added little additional content herself—the value is all in the organisation of the links to other sites—but on an internet where "everything is done by someone else" this makes a lot of sense. The weakness of the site is in the inevitably high proportion of dead links on a site that is maintained by hand.

The next step on from this is to generate a framework that harnesses the energies of your visitors and users. Hooking a backend database to serve dynamic pages isn't hard to do—it's not trivial, but it's within the powers of anyone willing to read a manual and diddle with a computer for a week or three. The problem is acquiring the necessary privileges to run applications (as opposed to merely serving flat HTML pages) on a web server. Cheap access to "always on" internet machines tends to be confined to academia or large commercial organisations, where the cost of hooking an additional machine to serve an internet application approaches zero. Although standard, consumer grade access over a dialup is also cheap or free, the functionality of the web spaces offered tends to be severely restricted for security reasons—and granting exemption to such rules means involving human beings who know what they are doing, always an expensive commodity.

The other weakness of the lone person website is its propensity to disappear. Though I found Melanie X's site on Monday, by Tuesday, just as we went to press, it had disappeared. Maybe by the time you read this it will have reappeared, but if not Sheffield University also hosts a site with a comprehensive looking set of links of interest to nurses (www.shef.ac.uk/~nhcon/).

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NETLINES

- If you use a palmtop computer (a Psion or Palm Pilot, for example) and want to find some healthcare applications then go to **www.PDAMD.com** for a whole range of services, including product profiles (hardware and software), news, and articles. Although it has a heavy US bias, there is plenty to offer everyone. It is a good all round site with some tasty links (they alone are worth a visit), and if you need a palmtop for your work or you just like gadgets then this site will appeal.

- The British Geriatric Society has produced a helpful website at **www.bgs.org.uk**. In fact it is a good model of how such an organisation or society should develop an online presence. It is easy to find your way around, with plenty of material to interest both members and lay visitors. It is up to date and informative, and provides zip files of the society's publications for downloading. All the usual sections—such as a list of future meetings, links to other sites, and details of local offices—are well represented. It should be bookmarked by anyone interested in geriatrics in Britain.

- Those interested in infectious diseases might find **http://pages.prodigy.net/pdeziel** to be an excellent launch pad to locate relevant material. Although it is basically just a gateway site, it does it with style by categorising its contents into useful subgroups. A link to the internet bookstore amazon.com's database helps locate textbooks on infectious diseases. A useful site map helps you to quickly focus on a point of interest. There is more than just infectious diseases here, though the web collections for surgery and emergency medicine may seem a little out of place.

- The UK based Sanger Centre, which is involved in work on genome projects, has put together a heavyweight website at **www.sanger.ac.uk**. The well laid out home page has plenty of detail, but if you don't see what you want then a visit to the elegant site map (an excellent model for other web editors to consider) should make navigation straightforward. Even for non-specialists, there is plenty of fascinating information about this fast moving specialty.

- The Department of Medicine of the University of California San Francisco collects guidelines on clinical practice and has listed them at **http://medicine.ucsf.edu/resources/guidelines/index.html**. The mainly text based interface is functional, and the material is easily accessible. There are plenty of guidelines from many specialties, and, with a few mouse clicks, it is easy to find the information you want. There are also some good links to other high quality resources and an in house search engine. Well worth a visit.

Harry Brown *general practitioner, Leeds*
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PERSONAL VIEW

Nurse practitioners and the future of general practice

In my daily clinical practice I work closely and happily with nurses who specialise in looking after patients with diabetes. An increasing number of tasks, previously the domain of doctors, are carried out by nurses. So why do I feel uneasy about the nurse practitioner in general practice?

Firstly, I am concerned that the title is not protected. A newly qualified nurse can be a nurse practitioner. At present they tend to have considerable experience and maturity—they have often spent several years as practice nurses or sisters in accident and emergency departments. But what of the future? When I receive a referral from a medical colleague I make certain assumptions about their training and experience. They will have gone to medical school, been through vocational training, and, almost invariably, be members of the Royal College of General Practitioners. When I receive a letter from a nurse practitioner, I have no way of knowing the background of the individual.

> When is a nurse really a doctor in all but name?

Secondly, I am concerned about the nurse practitioner courses currently on offer. The General Medical Council has a statutory obligation to oversee the standard of medical training in universities. The curriculum, teaching, and examinations are externally assessed. I would like to be reassured about the standard of nurse practitioner courses and the safeguards to assess such skills as history taking and clinical examination.

Until now, I could make a telephone call and see my general practitioner, for both medically trivial and more serious symptoms. If nurse practitioners become commonplace perhaps I will have to see a nurse before having access to my doctor. For many self limiting ailments this might be more cost effective, but where is the open debate among the profession and public to support this move? We are told that patients often prefer to see a nurse practitioner than a doctor in general practice, but if the choice is between seeing the nurse that day or waiting three days to see a doctor, what real choice does the patient who feels unwell have? If a member of my family or I were ill I would want to see my general practitioner. Why should we assume that our patients would be best served with something else?

We are facing a shortage of general practitioners especially in areas with declining industries or high levels of poverty. Will people in these deprived communities be given access to a nurse practitioner and be able to consult a general practitioner only if they are deemed ill enough? Perhaps the leafy suburbs of south east England will always attract sufficient general practitioners to see patients who insist on seeing a doctor with the MRCGP, whereas practices in deprived areas will increasingly offer a nurse led service.

When is a nurse really a doctor in all but name? I know little about ward management and would not presume to know how best to nurse a patient. If I wanted to run a ward I would take a degree course in nursing. Perhaps the minority of nurses who wish to take full medical histories, examine patients, and prescribe drugs should take a medical degree and enter the medical profession along traditional lines. For many people, time, family, and financial constraints are seemingly insurmountable impediments. Perhaps what is needed is a conversion course that will allow such nurses to become doctors without spending five years in medical school. Do nurse practitioners really want to be doctors and, if so, shouldn't we try to help them achieve this goal? Of course, this would mean that the NHS and practices would immediately lose the financial benefit of employing nurse practitioners.

My general practitioner colleagues tell me that they see much self limiting or trivial illness and that having nurse practitioners will give them more time. While I sympathise with this view—much of our acute medical intake is also self limiting or primarily of a social rather than medical nature—we need to ask, give them more time for what? Only if their time is to be filled dealing with things more important and productive than seeing patients can this argument hold water.

The ability to distinguish self limiting illness from serious disease and the opportunity to build up a close rapport with patients and their families by seeing them through a variety of illnesses over many years are key skills of general practitioners. If nurse practitioners take over seeing the supposedly trivial what will become of the doctor-patient relationship in primary care? We have been asked to take direct referrals from nurse practitioners, but perhaps if a patient is ill enough to see me in my clinic they are ill enough for their own doctor to take a look at them first.

Although this sounds negative, I am not necessarily opposed to nurse practitioners. It may be that they will provide the best route to providing primary care in this new century. At the other extreme, the introduction of nurse practitioners could undermine general practice as a profession, remove the right of patients to see a doctor without consulting a nurse first, promote inequality, and allow non-medically qualified people to practise as doctors.

John Alcolado *senior lecturer and consultant physician, Llantrisant, south Wales*

Doctors and nurses: new game, same result

In the beginning the relationship between doctors and nurses was clear and simple. Doctors were superior. They had the hard knowledge that made ill people better. The nurses, usually women, were good but not necessarily very knowledgeable. They were in charge of folding pillow cases and mopping brows. Nurses didn't cure patients; on the whole they still don't. They were just nice to them while they waited to get better.

In 1967 Dr Leonard Stein first outlined the doctor-nurse game. He said that the interactions between the two were carefully managed so as not to disturb the fixed hierarchy. Nurses were bold, had initiative, and were responsible for important recommendations. While being bold, however, they had to appear passive. In short, nurses were able to make recommendations as long as they made it look as if they were initiated by doctors. So the nurse was responsible for the well-being of her patients and the nourishment of the doctors' sense of professional self.

A missed opportunity for nursing and a bit of a bore for doctors

In 1990 Stein revisited the game and found that the nurses weren't playing any more. It seems they had unilaterally decided to change the way that they related to other health professionals. Nurses were tired of the handmaiden image and sought to invest their existence with a professionalism and value that they had previously been denied. Being a nurse was more than being a good woman; it was about being a well educated practitioner with independent duties, skills, and responsibilities.

After the 1970s nursing reconstructed itself as an independent profession which sometimes stood up to doctors. They did this in various ways, an example being the investment in university education and the social affirmation that went with it. Nursing was reinvented, increasingly as an associate science to medicine. But, why didn't these quasimedical nurses simply train as doctors? Is it because they believed in the distinguishing nature of nursing? Or because they didn't have enough A levels? Was the pursuit of equality motivated by a belief in the value of nursing or an inferiority complex?

For all the jostling for position over the past 20 years little has changed. This is primarily because the power in the relationship is mediated by the patient. If in doubt ask the patient who is in control. The public may love its angels but it holds its medics in awe.

In the struggle with doctors, nursing has made a fundamental error. It has mistaken equality for uniformity.

The frailty of nursing in the modern world is born of its intangibility. Nursing is more than treating ill people. It's about nourishment, problem solving, and easing a patient's experience of suffering, medical invasion, or death. It's always been hard to pin down, so it's not surprising that nurses have turned to the material world of postgraduate recognition, evidence based practice, expanded roles, and mimicking the medical career structure—nurse consultants, nurse practitioners, etc—in order to redesign their sense of self. The doctors, however, are still having their needs met by nurses.

Surely doctors are more than happy to see nurses do tasks that usually take up time and quite frankly bore them. Nurses are taking over tasks from junior doctors—administering intravenous drugs, doing endoscopies, preoperative assessment, and some prescribing.

Doctors are a simpler breed than nurses. Everyone knows what the doctor's job is. Doctors are the conduits of medical knowledge. They don't have to constantly redefine themselves. Doctors are little more than what science allows them to be. They are a totem. They don't rethink themselves, they don't need to. This gives them plenty of time and opportunity to redefine nursing.

Medicine remains in the ascendancy. The capacity to cure has greater market value than dealing with distress. And frankly so it should. But in the face of that might not nursing have done better than "if you can't beat them join them"?

In a short time nursing has built up an infrastructure of credibility from the wards to the universities, stopping off on trust boards and policy groups along the way. Nursing has garnered more governmental respect than ever. Unfortunately, this has been achieved by moving nursing towards convention, and the opportunity to move convention and credibility towards the core strengths of nursing has been missed. Nurses now have more power but arguably this has done little for nursing.

What feminism has done for nursing is to make young women choose to be doctors. As for the game, it doesn't matter. It is an irrelevant unsophisticated squabble. The key to the success or failure of the doctor-nurse relationship is the patient experience. Unfortunately, in the past the relationship has often been motivated by jealousy, self doubt, insecurity, and arrogance. You cannot help believing that this has been a missed opportunity for nursing and a bit of a bore for doctors.

Mark Radcliffe *deputy features editor, Nursing Times, London*

SOUNDINGS

Nursing matters

It is greatly to be hoped that the discord and indeed rancour that have characterised recent meetings of the medical staff committee of the newly reorganised Auchendriech United Acute Trust are simply a reflection of transition, as old interhospital rivalries are transformed by forward looking management into vibrant new complementarity and synergy. And it is perhaps a sign of progress that our meeting last Tuesday was one of the least contentious for months.

The only new item on our agenda so far this year had been raised by a senior surgeon who had heard rumours that management was about to bring in changes in nursing that would subvert consultant authority, erode the role of clinical judgment, and deprive junior medical staff of vital experience in practical procedures.

A broader discussion ensued. Nurse bed managers had yet again failed to cope with the winter crisis. Nursing jargon and previous nursing reorganisations had combined to replace ward sisters by "clinical managers with 24 hour responsibility for the ward level patient care area," so that the fine old tradition of coffee in sister's room after the ward round was now but a distant, golden memory.

Trends in nursing education were also briefly reviewed. The daughter of a consultant physician, in training in Edinburgh, had so far spent more time in the classroom on the sociology of nursing than she had in the wards nursing, and under tutors who were by all accounts refugees not only from the wards but from the real world too.

But nothing united our consultant body more firmly than a recent proposal to establish a new grade of "consultant nurse." Though for practical reasons our committee minutes are usually brief, a urologist insisted that his views on this concept—which he regarded as an insult, a betrayal, and a gross misuse of language—were for the record. And would these people insist on attending meetings such as this? He was sure that they would.

At 6 pm we were joined, as is usual every third meeting, by our chief executive. He was accompanied by the new director of nursing, a pleasant Glaswegian lady who outlined some over due and practical measures, developed by a joint medical and nursing working group, to extend the role of the nurse in several agreed areas. There were a few questions, followed by a brief and civil discussion. The meeting closed at 6 10 pm.

Colin Douglas *doctor and novelist, Edinburgh*